EXHIBIT A

CORPORATE HEADQUARTERS
Revolution Monitoring, LLC
Meridian Executive Suites
4925 Greenville Ave, Suite 200
Dallas, TX 75206

Consent for IntraOperative Neurophysiological Monitoring (IOM) Assignment of Benefits and Acknowledgment of Financial Responsibility

Patient: Date of Surgery:

Surgical Procedure:

Physician: Facility:

Neurophysiologist: Modalities: SSEP EMG TcMEP Train of Four H-Reflex F-Wave NCV
EEG Cortical/Subcortical Mapping EcoG ABR ECochG VEP

I give consent for IntraOperative Neurophysiologic Monitoring (IOM) during the course of my surgery as requested by my surgeon. I authorize Revolution Monitoring, LLC and designated employees or agents of such entity to perform the above mentioned modalities or any not included that may become necessary during my surgery. It has been explained to me that in order to provide such services the use of surface, intratracheal, and/or subdermal electrodes may be placed over muscles and/or neural structures over multiple sites as needed for this surgery. The risks of this procedure has been explained to me and may include but are not limited to infection, burns, seizures, bleeding at insertion sites, sore throat, issues due to jaw clenching or biting (tongue, cheek, lip lacerations, etc.) etc. Testing may commence before the start of surgery and will continue once started to the conclusion of the surgical procedure unless further study is requested by the above named surgeon.

Signature below also consents to request Revolution Monitoring, LLC to submit all invoices associated with the professional services performed during my surgery to my designated insurer or health benefits plan, on my behalf. I consent to and request that my insurance company reimburse Revolution Monitoring, LLC directly for any invoices submitted on my behalf for professional services rendered by the above named company. If for any reason my health benefits plan or insurance company does not reimburse Revolution Monitoring, LLC directly for services rendered on my behalf and reimburses me, I agree to send all payments by my insurer for IntraOperative Neurophysiologic Monitoring and all explanation of benefits to Revolution Monitoring immediately. Failure to remit such payment would make me legally responsible for the reimbursement of Revolution Monitoring, LLC the full amount of their professional fees, co-payments, co-insurance, or deductible amounts for which I am responsible, for delivery of IntraOperative Neurophysiologic Monitoring performed during my surgery. I am also aware that I am legally held responsible for the costs of the IntraOperative Neurophysiologic Monitoring services in my health benefits plan or insurance company fails or refuses to remit the costs for such services.

I authorize Revolution Monitoring, LLC and/or its attorneys to file any necessary claims, demands, or appeals with my insurer or health benefits plan from a denial of reimbursement or coverage for IntraOperative Neurophysiologic Monitoring services provided on my behalf. I also assign Revolution Monitoring, LLC my rights to bring legal action, if needed, against my insurer or health benefits plan to recover the costs of or enforce my rights to coverage of IntraOperative Neurophysiologic Monitoring services under my insurance or health benefits plan under applicable law, including without limitation under the Employee Retirement Income Security Act of 1974.

I understand that Revolution Monitoring, LLC may disclose personal health information (PHI) related to receipt of professional services for the purpose of enacting such as actions as defined above. I agree to provide the necessary information to and reasonably cooperate with and assist Revolution Monitoring to pursue third party payments of my claims for IntraOperative Neurophysiologic Monitoring services.

If you would like to decline to allow Revolution Monitoring, LLC to submit any and all claims for reimbursement to your insurer, please initial next to the box stating that you accept all legal responsibility for self-payment of professional services.

_____I do not want Revolution Monitoring, LLC to bill my insurer on my behalf and/or do not have an insurer. I agree to be responsible directly to Revolution Monitoring, LLC for any charges associated with monitoring of my surgery

My signature below indicates that I consent to these procedures and have been made aware of my benefits and financial responsibility

☐ The patient was in the operating room and/or was under anesthetic sedation and unable to sign the consent form

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Neurophysiologist: _____Date: _____

TcMEP Concerns: ____Intracranial metal (DBS, Cochlear Implant, Skull Plating) ____Seizures ____ Skull Defects ____Pacemaker

Medical History: ____Weakness UE/LE; L/R ____ Pain UE/LE; L/R ____Numbness UE/LE; L/R ____Tingling UE/LE; L/R ____Spasticity UE/LE; L/R ____Clonus
____ Balance issues ____Bowel/Bladder Incontinence ____Diabetes ____ Hypertension____ Stroke/TIA ____Dizziness ____Slurred Speech
____Memory Loss ____Cognitive Dysfunction ____ Headaches ____Vomiting/Nausea ____Vision Issues/Loss/DV ____Hearing Deficit/Tinnitus
____Facial Weakness/Numbness/Pain ____Difficulty Swallowing ____ Language/Speech Aphasia: Absence/Expressive/Comprehensive